

Community Health Status Assessment At-A-Glance

The Community Health Status Assessment (CHSA) answers the question, “How healthy are our residents?” and “What does the health status of our community look like?” The results of the CHSA provide the MAPP Committee with an understanding of the community’s health status and ensure that the community’s priorities include specific health status issues (e.g., high lung cancer rates or low immunization rates).

The CHSA provides a list of core indicators (data elements) for 11 broad-based categories. Communities may also select additional indicators. By gathering data for each of these and comparing the jurisdiction’s data to trend information or peer, state, and national data, health issues are identified.

Recommended Participants and Roles:

- ?? Subcommittee — designs and prepares for the CHSA process, oversee the collection and analysis of data, and compile results.
- ?? MAPP Committee — oversees subcommittee activities, provides recommendations for collecting data and gathering community input.
- ?? Broad Community Involvement —should already be incorporated into the committee membership, however, if additional participants are desired for this process they should be recruited.

A Step-by-Step Overview of the CHSA Phase:

1. Prepare for the CHSA, by establishing a subcommittee and planning how the CHSA steps will be undertaken.
2. Collect data for the core indicators on the CHSA indicator list. Review previous assessment efforts and build from these, as needed.
3. Select additional data indicators to explore issues important to the community. Identify additional data indicators by reviewing the list of extended indicators or by developing locally-relevant indicators. Collect data for the additional indicators.
4. Organize and analyze data and present it in understandable charts and graphs. Compile the findings and disseminate them throughout the community (e.g., via a published document, a series of fact sheets, or a website).
5. Establish a system to monitor the indicators over time. Modify or add to the indicators periodically, as new information arises from other phases of MAPP.
6. Identify challenges and opportunities related to health status that should be considered during the next phase, Identify Strategic Issues.

Community Health Status Assessment


Introduction to the Community Health Status Assessment


The Community Health Status Assessment (CHSA) answers the questions, “How healthy are our residents?” and “What does the health status of our community look like?” The result of this phase is a strong understanding of the community’s health status, as portrayed through quantitative data.

The information gathered in the CHSA, along with information generated by the other three MAPP Assessments, will comprise the four sources of information to be considered during the Identify Strategic Issues phase.

The CHSA is a crucial component in the MAPP process, as it is during this stage that specific health issues (e.g., high cancer rates or low immunization rates) are identified. A broad range of data serves as the foundation for analyzing and identifying community health issues and determining where the community stands in relation to peer communities, state data, and national data. Because this activity is a core capacity of public health agencies, it may be appropriate for the local health department to play a lead role.

It is important to anticipate the following challenges to conducting a CHSA.

 Collecting and analyzing a broad range of data is **time-consuming**. To address this challenge, the Organize for Success/Partnership Development guidance recommends that data collection begin early in the MAPP process. This will help to condense the timeline for the CHSA phase.

 Data collection and analysis is **resource intensive**. Collaboration among local public health system partners helps utilize resources more effectively. The state health agency may also be able to provide assistance by providing data or assisting with analysis.

The Role of the Community in the CHSA

While the majority of data collection will likely be conducted by a small number of organizations, community perspective is vital to the CHSA. The health of the community affects virtually all community interests, including business, education, health care, and public health and safety. Input from the entire MAPP Committee should be considered when selecting the data indicators that will describe the community’s health status.

What Does a Community Health Status Assessment (CHSA) Entail?

By conducting the CHSA, communities gather a variety of data related to the 11 categories listed below.¹ The categories directly measure health or related contributing factors which significantly affect community health. Definitions for each category can be found within the [CHSA Indicator Listing](#).

Who are we and what do we bring to the table?

1. Demographic Characteristics

¹ Note: The 11 categories are based on the framework of the University of South Florida’s Comprehensive Assessment for Tracking Community Health (CATCH) program.

2. Socioeconomic Characteristics
3. Health Resource Availability

What are the strengths and risks in our community that contribute to health?

4. Quality of Life
5. Behavioral Risk Factors
6. Environmental Health Indicators

What is our health status?

7. Social and Mental Health
8. Maternal and Child Health
9. Death, Illness and Injury
10. Infectious Disease
11. Sentinel Events

Each category includes indicators, or data elements, that reflect the most relevant measures. For each category, there are core indicators and extended indicators. Core and extended indicators are defined as follows:

Core indicators — Data elements that MAPP recommends all communities collect and track. The core indicators have a higher priority based on the critical nature of the data, the potential for comparative value, and the relevance for most communities. The core indicators have been cross-referenced with other current initiatives. They include the 25 indicators recommended in the Institute of Medicine’s report “Improving Health in the Community.” Many of these indicators and their associated data can be found in the Community Health Status Indicators county-level reports. (www.communityhealth.hrsa.gov). This attempt to standardize measures across all communities enables decision-makers to compare their community’s health status with others and to monitor changes over time.

Extended indicators — A menu of additional indicators from which communities may select to explore issues of importance to the community. The extended indicators within MAPP provide a “starting point” for additional indicators; communities are strongly encouraged to go beyond this list and identify new indicators where needed.

How to Conduct the Community Health Status Assessment

Below is a description of each of the CHSA steps. As with other phases of the MAPP process, the CHSA should be tailored and customized to your community’s needs. The following case vignettes provide examples of how three communities undertook a broad-based community health assessment and how it helped to drive their planning process:

CHSA – Miller County Example,

CHSA- Peoria Example, and

CHSA-Chicago, IL Example.

Step 1 – Prepare for the Community Health Status Assessment

Begin by establishing a subcommittee to oversee this portion of the MAPP process and to be accountable for the CHSA activities. Thoughtful selection of participants will help to ensure access to data, provide for epidemiological analyses of data, and facilitate community ownership of the completed health status profile. Membership in the subcommittee should not be limited to heads of agencies or organizations and might include those most knowledgeable about data availability, analysis, interpretation, and presentation. Community representatives should be included, as they provide an important perspective. In addition, since it is critically important that data be monitored long term, select some members who can participate in future years. This is not just an ad hoc, one-time effort.

Once the subcommittee is assembled, members should review the CHSA steps. They should also identify the skills and resources needed to conduct the activities. Resources may include computer hardware and software for gathering and analyzing the data, copying or printing costs for health profiles or fact sheets, and staff support. Also determine whether or not epidemiologists in the state public health agency or elsewhere are available to assist in data collection or analysis.

In some communities, it may make sense to pool financial resources and subcontract the data collection and analysis to a private consultant, one of the partners, or a university. This is one way to expedite the process; however, due to the on-going nature of the community health assessment process, it is recommended that the capacity to monitor and track indicators be developed within the community.

Step 2 – Collect data for the core indicators on the CHSA indicator list

Data collection may require considerable time and effort. Therefore, it is important to begin this activity early in the MAPP process. The Organize for Success phase recommends beginning data collection at the beginning of the MAPP process, so this should already be underway.

Trend and comparison data are very important. Attempt to collect a minimum of five years of trend data to analyze trends over time. Comparison data — state, national, and peer community data — should also be collected during this phase.

To facilitate data collection, the “core” requirement for data for MAPP has been kept to a minimum. If the data specified are not available, subcommittee members should work together to find additional data resources.

Below are some suggestions for identifying data sources for indicators:

- Use state or local databases.*** Many CHSA core indicators may already have been collected by local or state agencies. The state public health agency is an especially useful resource.
- Access previously conducted health assessments or reports that include data.*** Previous assessments or planning reports can be a gold mine for information. Collect health assessments conducted by community coalitions, hospitals, health departments, and other organizations. These data can provide useful benchmarks for identifying trends and can also offer tips on where to find current data.

- Identify MAPP Committee members who may have access to data through their organizations.** For example, a hospital representative may be useful in gathering hospitalization or admissions data, while a law enforcement representative may have access to data for the crime or violence-related indicators.
- Identify volunteers from within the subcommittee to “track down” hard-to-find data.** Gathering some data may require some hard work. For example, several of the indicators in the Health Resource Availability category require information on licensed providers. A volunteer may be needed to establish contact with the state’s licensing entity to gather the information.
- Consider whether new sources need to be established.** For example, sources for injury data could include hospital admission records, the YM/WCAs, private sector recreation businesses, and insurance companies.

New data collection need not “bog down” the current initiative unnecessarily. In fact, the need for data may become an issue to be addressed in the Identify Strategic Issues phase. If some data are unavailable or extremely difficult to gather, continue moving the process along and include the need for a stronger data collection system on the list of “challenges” that result from the CHSA.

Step 3 – Identify locally-appropriate indicators and collect the data

The selection of locally-relevant indicators helps the MAPP Committee better describe the community’s health status and quality of life in terms that are of particular interest to the community.

Additional indicators might be selected for the following reasons:

- Community interest in a specific topic** – The discussions held with community residents (during Community Themes and Strengths activities or the Visioning phase) will have identified issues of importance to the community. If community residents expressed concern about violence prevention, select additional indicators such as intentional and unintentional deaths and weapons-related assaults or deaths.
- Exploration of issues important to the demographics of the jurisdiction** – Consider the population within the jurisdiction to determine issues to be further explored. For example, a community with a large senior population may be particularly interested in chronic disease, the number of nursing home beds, access to screening, and post surgical or stroke rehabilitation programs.
- Further exploration of issues identified in the core indicators** – Determine whether core indicator data warrant further exploration of an issue. For example, if a county’s death rate from breast cancer is high, extended variables might include mammography screening rate and percent of breast cancers diagnosed at an early stage.

The entire MAPP Committee should review the extended indicator list and discuss the need for other indicators. As they do this, they should keep in mind the discussions and results from previous phases. The discussions held during the Visioning phase and the Community Themes and Strengths phases may provide meaningful insight into issues of importance for the community.

Because the data needs of the CHSA process may appear overwhelming, especially in small jurisdictions, there should be a reasonable process for selecting only those of high priority and relevance.

Some communities will be particularly interested in considering additional locally-appropriate environmental health indicators. The NACCHO *Protocol for Assessing Community Excellence in Environmental Health (PACE EH)* offers a community-driven methodology for selecting environmental health indicators.

Step 4 – Organize and analyze the data; develop a compilation of the findings; and disseminate the information.

Individuals with epidemiology expertise, computer skills, and statistics experience should support the data collection and analysis processes. Small jurisdictions may want to contact the state health agency or academic institutions for epidemiological assistance.

Information technology is a powerful tool for gathering and analyzing public health data. Use computer-based resources to: a) enter, analyze, and transmit community data; b) gather and analyze national and state data; and c) translate CHSA data into relevant, understandable, and community-specific terms.

At a minimum, it is recommended that data be analyzed using demographic, socioeconomic, and mortality measures. Additionally, analyzing data according to age, gender, racial, and population subgroups offers crucial insight into health disparities. Trend information and comparisons with peer communities, state, and national data can also highlight health status issues. Connections should be made between indicators in different categories. For example, smoking-related behavioral risk factors (Category #5) might correlate with high smoking-related cancer rates (Category #9).

Consider whether steps are needed to ensure that data are valid and usable. Sparsely populated small communities and neighborhoods have the unique challenge of interpreting "low numbers or incidence" into usable information. For suggestions on how to address this issue, see the Tip Sheet – Data Issues in Jurisdictions with Small Populations.

Next, develop a compilation of the findings or a “community health profile.” The community health profile should include visual aids, such as charts and graphs, that display the data in an understandable and meaningful way. See the Tip Sheet – Presenting Data for more information. If possible, publish a report summarizing the findings. If this is not feasible, a series of fact sheets or a central website may be equally useful. What is important is that the information is compiled and made available through one central location.

Finally, the community health profile should be disseminated and shared with the community. Develop a proactive dissemination strategy, including:

- ✍ promoting the information through the **media** (newspapers, local television, or radio stations). This helps to reach a broad audience. See the Tip Sheet – Engaging the Media for more information.

- ~~✍~~ utilizing **grassroots connections** to disseminate the profile to certain segments of the population. This helps to sustain the involvement of hard-to-reach populations. Meetings of civic groups and local associations are useful venues.
- ~~✍~~ presenting information to **elected officials or town leaders**. This builds support for the results and lays the groundwork for activities in later phases of MAPP.

An endorsement of the community health profile by key stakeholders and its broad acceptance by the community provides evidence of the success of this step. Stakeholders should recognize the community health profile as the standard reference for health status. Their use of the profile within their own assessments or for their own purposes — such as grantwriting — conveys this endorsement. Multiple sectors — such as transportation or education — should be encouraged to incorporate the results into their activities. Similarly, the community should recognize the report as a *community* report, not a health department report, which may help to recruit and attract others to the overall effort of improving health status.

Step 5 – Establish a system to monitor the indicators over time

During this step, the subcommittee establishes a system for monitoring the selected indicators. This helps to ensure that continuous health status monitoring occurs and establishes baseline data upon which future trends can be identified. This system will also be instrumental in identifying the results of the MAPP process and evaluating the success of the MAPP activities.

First, review the agreed-upon set of indicators and determine who will be accountable for monitoring. Sustainable monitoring systems require a clear definition of roles, including leadership, coordination, and communication. One organization, such as the local health department, should take the lead in maintaining and regularly examining the data for significant changes. However, a variety of organizations should participate in monitoring activities to ensure that data is collected on an ongoing basis.

Data for some indicators may be limited or unavailable. The CHSA subcommittee should explore methods for gathering this data. If data are not available for critically important indicators, there may be a need to consider this as a major strategic issue.

The CHSA subcommittee should also come to an agreement about the elements of the monitoring system and consider issues such as:

- ~~✍~~ the frequency of data collection,
- ~~✍~~ the quality of data,
- ~~✍~~ continuing comparisons to peer, state, or national data,
- ~~✍~~ the need to modify or add indicators,
- ~~✍~~ methods for maintaining the data systems, and
- ~~✍~~ communication mechanisms to assist in keeping the monitoring system in place, updating data, identifying changes in data, and coordinating between entities.

Keep in mind that it is important to modify or add to the indicators over time. The monitoring system should be responsive to new information that arises from the other three MAPP Assessments and from the selection of strategic issues. The monitoring system is especially important to the evaluation component of the Action Cycle.

Step 6 – Identify challenges and opportunities related to health status

The CHSA phase should result in a list of challenges and opportunities related to the community's health status. This information will provide crucial input into the next MAPP phase, Identify Strategic Issues.

Data findings should be reviewed to identify challenges and opportunities. Revisit trend data, as well as peer, state, and national comparisons. Examples of challenges that might emerge from this effort might include major health problems, a significant disparity in health status between ethnic/racial groups, a cluster of health determinants, or evidence of a systems failure that didn't detect or address a problem. Examples of opportunities include trends that show improvements in health status or the number of providers being adequate to meet needs.

Working together, partners should examine the CHSA results in light of the questions listed below. Ideally, the final list will include 10-15 community health status issues that will be more closely examined in the Identify Strategic Issues phase of MAPP.

1. Does this health problem affect large numbers of people, have serious consequences, show evidence of wide disparity between groups or increasing trends, and is it susceptible to proven interventions?
2. Does the issue have broad implications over the long term for potential health improvements?
3. By addressing this issue, is there potential for a major breakthrough in approaching community health improvement?
4. Is this issue one that has been persistent, nagging, and seemingly unsolvable?
5. Does this issue identify a particular strength that can be replicated throughout the community?
6. Is ongoing monitoring of this issue possible?

Community Health Status Assessment Miller County, GA Vignette

With a population of approximately 6,000 residents, Miller County, GA, is a small rural county, located in the southwestern corner of Georgia. In 1997, a coalition of community organizations and representatives in the county embarked on a community strategic planning process to improve the healthcare system. As part of the process, the coalition conducted a broad-based community health status assessment.

To inform the planning process with accurate information about the health status of Miller County, a varied set of objective and subjective data was collected. Because the focus of the planning process was on the healthcare system — the local hospital, in particular— much of the data collection focused on information specific to health care services.

The elements of the data collection included:

- ✎ *Demographic and Health Status Reports* – These included population, economic, education, employment, health status, and crime data.
- ✎ *Claritas Marketing Database Information* – Claritas, Inc., a national marketing company, develops cluster health profiles about the lifestyle of communities (including commonalities such as age, ethnicity, race, education and income, consumer preferences, and neighborhood location).
- ✎ *Community Asset Mapping Results* – Available resources in Miller County were identified, including employers, lending institutions, healthcare, churches, civic organizations, and cultural groups.
- ✎ *Community Health Assessment Survey* – A survey was distributed to learn about resident perceptions related to: 1) the most important health issues; 2) issues for which services were the least adequate; and 3) the health problems of highest priority.
- ✎ *Key Informant Interviews* – Coalition members conducted open-ended interviews with 70 community residents to identify overall needs and perceived problems.
- ✎ *Telephone Opinion Survey* – A randomized telephone opinion survey to 260 Miller County residents provided information about the quality of healthcare in the county and perceptions about and use of the Miller County Hospital.
- ✎ *Economic Impact Study* – An economic impact study explored the direct and indirect impact the hospital has on the community.
- ✎ *Regional Asset Mapping* – A study was conducted to identify health services available within Miller County's potential market area.
- ✎ *Health Services Dollars: Patterns of Use* – This study was completed to describe how Miller County health care needs are currently being met and to identify opportunities for improvement. Claims data from Medicaid, Medicare, and Merit System employees were used.

Miller County collected a broad array of objective and subjective data that was used for well-informed decision making. The data collection efforts also show how the coalition collected traditional data, but also focused their efforts on areas important to the strategic plan.

Community Health Status Assessment Peoria City-County Health Department, IL Vignette

The Peoria City-County Health Department (PCCHD) in Illinois serves a total population of approximately 130,000. In 1992, in response to the Illinois Project for Local Assessment of Needs (IPLAN), PCCHD conducted an internal organizational assessment and a community assessment process.

In January 1993, the Board of Health appointed a 15-member Community Health Needs Assessment Committee (CHNAC) to assist in implementing the development of a community health plan. In May, the CHNAC met for the first time and approved the following statement as its purpose: "To identify, assess, and prioritize the health needs of Peoria County residents." The final product would be a plan with strategies for addressing the community's priority health issues.

PCCHD advised the committee that data were available that related to the health department's identified problems. A nominal group process was suggested and then selected as a means of identifying the perceived needs within the community. The health problems identified by statistical measures were then provided to the committee, which integrated them with the perceived needs and prioritized community health problems.

CHNAC recommended additional community input into the process. The committee identified and surveyed 25 social service agencies for input into what they perceived to be the most important community health needs.

Using the data, the committee perceptions, and the agency survey, CHNAC identified 12 health problems, conducted a prioritizing process, and produced the following four highest ranked community health problems.

- | | |
|----------------------------------|-----------|
| 1. Infant Mortality | 3. Stroke |
| 2. Sexually Transmitted Diseases | 4. Cancer |

The health officer and the Board of Health independently identified positive results within PCCHD, including an increased appreciation for other staff and programs and more confidence in their work responsibilities and environment. In the community, results included improved communication with partners, new services (family planning in a community hospital), and improved relations with the Board of Health.

Community Health Status Assessment Chicago, IL Vignette

The Chicago Health Profile was compiled largely by staff, with the Chicago Partnership determining the elements that would be included. At a February 1999 partnership meeting, members were presented with a preliminary list of data elements that might be included in the profile. They made additions to the list as well as questioning the need for some of the data elements. Agreed-upon elements fell into five categories:

- demographic and socioeconomic indicators,
- health status indicators,
- health perceptions and health-related behaviors,
- social and environmental factors, and
- health care delivery and access to care.

A variety of data sources were used to obtain information in the above areas. These included: the U.S. Census, vital records and reportable diseases (maintained by the Public Health Department), hospital discharge data, adult and youth behavior risk factor surveys, violent crimes from the police department, and a recently-completed broad-scale survey of Chicagoans.

Once the data were collected, staff drafted a 37-page narrative report (with data tables attached) and distributed it at the partnership's June meeting for review and future discussion. Members were asked to contact staff over the next two months with any recommended changes. Staff then synthesized the profile's findings into a seven-page summary and presented this information at the partnership's September 1999 meeting. Among the profile's key findings:

- Significant health status disparities exist by race/ethnicity and by gender.
- The city experienced a 12 percent decrease in available jobs from 1992 to 1997, although the past two years have seen a slow growth in new jobs.
- While mortality rates overall are declining, hospitalizations for related conditions were up.
- Infant mortality rates continue to decline, despite no decreases in low birth weight births.
- Having decreased significantly in recent years, most types of sexually transmitted diseases have increased in the past year.
- Most Chicagoans have some source of regular medical care; most of the insured are not covered for wellness services.

Members discussed the findings and their implications. The decreasing mortality rates (including infant deaths) and rise in hospitalizations, along with the lack of improvement in low birth weight births, suggested to members that while advances are being made in medical intervention, more work is needed in the area of primary prevention.

Tip Sheet – Presenting Data










The MAPP process will generate a great deal of data. It is important that these data are well understood throughout the community. Presenting data in a clear and concise manner helps emphasize the important findings and results of the MAPP Community Health Status Assessment process.

Data can and should be presented in variety ways. These include:

- written updates of the process (e.g., newsletters, reports, and summaries of findings);
- presentations made to the community and media, and
- the maintenance of an open and public process.

Presenting Data in Written Reports (Newsletters, reports, and summaries of findings)

Helpful Hints:

-  Use an attractive and colorful layout.
-  Keep the community and media updated throughout the process.
Consider launching a newsletter or publishing information in a report.
-  Highlight only the important facts or findings. Don't waste space on details.
-  Use clear, simple charts. The easier they are to understand, the better.
-  Summarize major findings in as many places as possible.
-  Write in a clear, simple style that can be understood by readers without a public health background.
-  Acknowledge community perceptions of public health. If there is a specific area of interest, address it.
-  Know your audience. Carefully select visual aids and language that will be understandable and interesting to participants.
-  Double check all data and information presented. Incorrect data can affect the perceived credibility of the presenter and of the entire process.

Oral Presentations

Helpful Hints:

- ~~/~~ Keep presentations **brief** — less than 30 minutes per issue.
- ~~/~~ Invite special interest groups and representatives from all community organizations.
- ~~/~~ Cover only the highlights. What is unusual, either in number or by trend? What finding may be of particular concern to the community?
- ~~/~~ Use visual aids that highlight only important information. Clear, simple charts get the point across better than numbers.
- ~~/~~ Stimulate interaction. Encourage discussion about areas of specific interest.
- ~~/~~ Be organized. Have information on hand that may be of interest to participants.
- ~~/~~ Use everyday language. Scientific or statistical jargon may be unnecessary and confusing.
- ~~/~~ Keep it simple. Be clear and concise.
- ~~/~~ Summarize. Spend the last two minutes reviewing the major findings so that participants don't get lost among all the facts.
- ~~/~~ Give participants summary handouts and fact sheets.
- ~~/~~ Check equipment in advance to ensure they function properly. Have back-ups available in case of equipment failure.
- ~~/~~ Use maps of geographic areas to show what the information means to different communities or neighborhoods.

Tip Sheet – Data Issues in Jurisdictions with Small Populations

Data collection is an integral part of the assessment function of public health. The challenge is to collect and convert data into useful information that provides a composite picture of the community's health. Many states have improved data systems and are regularly supplying data to local health departments for their jurisdictions. If such data are not available from state agencies, the process will require time, people, community resources, and possibly consultants who can analyze the data and convert it into an easily understood format.

Sparsely populated or small communities have the unique challenge of translating "low numbers or incidence" into usable information. Low numbers or incidence can produce unstable rates that greatly fluctuate from year to year. In addition, a "snapshot" view of one year may not adequately represent the true status of the community's health. Also, smaller communities may not have access to individuals with expertise in data analysis. For these reasons, the collection and analysis of data may be an especially large barrier to community health assessment in communities with small populations.

Statistical Instability

There are two potential ways to avoid or address the statistical instability with which jurisdictions with low populations are faced. It is recommended that such communities consider one of the following approaches:²

- ?? Combine multi-year data (e.g., data for three years). A drawback to this option is that looking at multi-year data limits the ability of the jurisdiction to monitor program interventions and identify new trends. Rolling year averages (e.g., looking at data for 1997-2000 one year, and 1998-2001 the following year) may overcome this drawback and should be considered.
- ?? Expand the geographic area by conducting a regional health assessment in collaboration with neighboring jurisdictions. A drawback to this option is that the community may then be looking at geographical areas over which it has no control. Analyzing data at the regional level may also mask interesting local variations in the data.

Both of these approaches increase the number of events under analysis. It is recommended that all indicators be based on 20 or more events (i.e., infant deaths, low birth-weight infants, etc.) In general, the higher the number of events, the more stable is the data. Confidentiality issues must also be considered when the number of events is small.

Other Data Considerations

The following tips may be useful to small or rural communities that do not have access to epidemiological expertise in data analysis.

² American Public Health Association. Healthy Communities 2000: Model Standards. Washington, DC: 1991, pp. 458-459.

Data should be considered in light of the following questions: What are the sources of these data? Are the sources reliable? What are the issues raised by the data? Are key pieces of information missing and can they be obtained? Are there any other considerations regarding the health issue that need to be taken into account when analyzing the data? Can a summary statement be made about the numbers?

Consider the following issues:

- ?? The manner in which the data are collected is very important. In analyzing communicable disease information, consider the reporting system that exists in the state or locality and the kind of data that would be produced.
- ?? Consider the sampling frame used in gathering the data to ensure that all special high-risk populations are included. For example, university populations should be included when looking at youth issues, while nursing home or retirement communities should be included to get a valid rate for aging issues.
- ?? Consider time-related issues when looking at certain health issues or diseases (i.e., the amount of time it may take for a program intervention to show results). For example, a decrease in cancer rates may be indicative of the success of program interventions that took place many years earlier.
- ?? Years of Potential Life Lost (YPLL) is a good indicator that can provide additional information about the important causes of premature death in a community. For example, consider the number of deaths due to injuries in a community. Although the actual number of deaths due to injuries might be low, the impact of this problem could be highlighted if the YPLL is high (indicating that deaths due to injuries cause a disproportionate loss of potential productivity in younger populations).
- ?? Consider that a substantial change in a single indicator (e.g., number of cancer deaths increasing from 20 to 30 [or a 50% rise] over one year) may not necessarily represent a trend or pattern. While troubling to the community, this may be a normal variation in reporting. Situations like this may present an opportunity to engage the community in the science of epidemiology. Exploring risk factors may increase the participants' appreciation for health planning, health assessments, and related activities.